STRICK C. MAYS, M.D.
SUSAN GRIFFIN, ARNP
131 E. Redstone Ave Suite #109
Crestview, FL 32539
Tel. # 850-683-1100
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AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

I hereby authorize disclosure of my records from: _____
(Physician's Name)

_____Dr. Strick Mays
_____ Susan Griffin, ARNP

The information may be disclosed to : _____
(Physician's Name)

Patient Name: _____ Chart # _____
Date of Birth : _____ Social Security #_____

Please disclose the following information : (Check one box for each item)
□Complete Medical Records (2 Yrs. only) □ Physician Notes □ X-Ray/Ultrasound Reports
□ Alcohol & Drug Therapy □ Mental Health Treatment Records □ Lab Reports
□Other (Please Specify) _____

Purpose of Request _____ Date of Treatment _____

I understand that the information in my record may include information relating to sexually transmitted Diseases, AIDS/HIV. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for redisclosure and that information then may not be protected by federal confidentiality rules.
I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

_____ _____
Patient Signature/Legal Rep. Signature Date